Raised Bill 1052
An Act Concerning Maximum Allowable Cost Lists and Disclosure by Prescription Benefit Managers

Insurance and Real Estate Committee Hearing
Tuesday, March 17, 2015

Senator Crisco, Representative Megna, and the Distinguished Members of the Insurance and Real Estate Committee:

My name is David Benoit. I am a pharmacist and currently am employed as Vice-President of Patient Care Services for Northeast Pharmacy Service Corporation, a buying group (GPO) representing the majority of independent pharmacies in Connecticut and nearly three hundred in New England. I have been involved with contracts for prescription drug programs for nearly twenty years. I am here to testify in support of Raised Bill 1052 An Act Concerning Maximum Allowable Cost Lists and Disclosure by Prescription Benefit Managers.

I offer apologies from many pharmacy owners who could not be here today because they are attending a UConn Pharmacy Continuing Education and Certification and Training Program.

Maximum Allowable Cost (MAC) was implemented by the federal government in August of 1976, many years before the introduction of personal computers. The primary reason for the program was to create savings in the use of generic drugs. At the time, there were still many who believed that generics were inferior products. In 1977, the federal government required that multisource generic pharmaceuticals be shown to be bioequivalent to the name brand. The program was administered by the Health Care Financing Administration (HCFA). State Medicaid programs used the HCFA MAC to pay multisource prescription drugs.

Eventually HCFA was replaced by the Centers for Medicare and Medicaid Services (CMS) but the MAC remained.

In order for a product to be included on the MAC list, it had to be generally and consistently available from multiple sources. Eventually, that came to mean that there were at least three competitive

products available. The MAC was a single unit price that was set based on the availability of numerous products that were widely available for pharmacies to purchase at or below that MAC.

Over the course of the '80s and '90s, many commercial plans adopted the HCFA MAC as their basis for reimbursing multisource generic products. Through the '90s and beyond, the Prescription Benefit Managers (PBMs like Caremark and Express Scripts) morphed the MAC into their individual secret, proprietary process in place today.

At one time, it was very unusual for a pharmacy to get paid less than cost for filling a prescription. Curiously, the generic industry, which provides the low cost competitive pharmaceuticals, has been in a state of consolidation and product discontinuations. Prices in many cases have increased 1000% and more from one day to the next. Right now, there are over 1,000 products that pharmacies have petitioned the payers to adjust prices to reflect reality – a far cry from just a few years ago.

Community pharmacies are small businesses that support local communities, create jobs, buy benefits and pay taxes. These MAC underpayments, representing $100,000 per store in 2014, are a direct reduction in the state's economy.

I know that fair market pricing of generics was possible and that it still is. In today's market of generic company consolidations, the PBMs aren't keeping up with massive generic pharmaceutical price increases. It is also a significant challenge to keep up with the volume of price increases, which is unprecedented.

Let me say clearly: We aren't asking you to give us a raise. We are asking that when manufacturers raise prices, PBMs raise reimbursements in line with the manufacturer's increase. When new generics come out, they are very timely in following the competitive price reductions down. They could just as easily follow them up. We tell them that the price has gone up when we file a request to update reimbursements. They only need to verify our claim and make adjustments accordingly. That should not take six months, during which time Connecticut's pharmacies are underpaid. This is an unsustainable business model.

Sixteen states have already passed MAC legislation. Of the ten states that have MAC legislation before them in this session, six are here in the Northeast; New York, Connecticut, Rhode Island, Massachusetts, Maine, and Vermont. We have attached a map illustrating this wave of attention to MAC issues.

Raised Bill 1052, AAC Maximum Allowable Cos Lists and Disclosure by Prescription Benefit Managers mandates that PBM contracts include a process enabling network pharmacies to appeal reimbursements that are below cost. The right to appeal is fundamental due process that appears throughout state and federal law. CMS currently requires Part D contracts to include a MAC appeals process, such as the one created in this bill. Beginning January 1, 2016 CMS also requires that generic MAC prices reflect actual market prices.

The mandate in this bill also reflects the generic price appeals process in effect for Connecticut's state Medicaid program.

Raised Bill 1052, seeks to enhance transparency by requiring PBMs to disclose whether the same MAC list is being used to pay the pharmacies and to bill the plan. This transparency would level the playing field among PBMs when plans are evaluating PBM contracts.

Some basic premises of the contract between a pharmacy and a PBM are: The PBM wants the pharmacy to fill their cardholders' prescriptions; the pharmacy wants to fill those prescriptions; and, the payments for filling prescriptions are fair, reasonable, and acceptable. We ask only that these principles be adhered to.

I would like to suggest amending Section 1, f, 2A. In line four of the paragraph, it should say "...at a price equal to or GREATER (not less) than the maximum allowable cost...." I would also like to suggest that it be very clear that published MAC list updates must include updated pricing.

Imagine that the IRS mileage limit is only half of what it costs to operate your car. What do you do? Find a car that can be operated below the reimbursement. If you cannot, then you must ask the IRS for a reevaluation. If the IRS refuses, maybe you use substitute transportation – busses, cabs, or walking perhaps. None of these is as effective as a correct payment amount.

PBM finances should not interfere with the choice of cost-saving multisource medication that the physician has chosen for the patient. Patient access to cost-effective multisource generics should be a guarantee.

Last year, industry stakeholders in Connecticut came together to offer pharmacy audit legislation that was passed into law. Pharmacy stakeholder groups are getting together in Rhode Island to work on MAC legislation. The same should be possible here in Connecticut.

Please support Raised Bill 1502.

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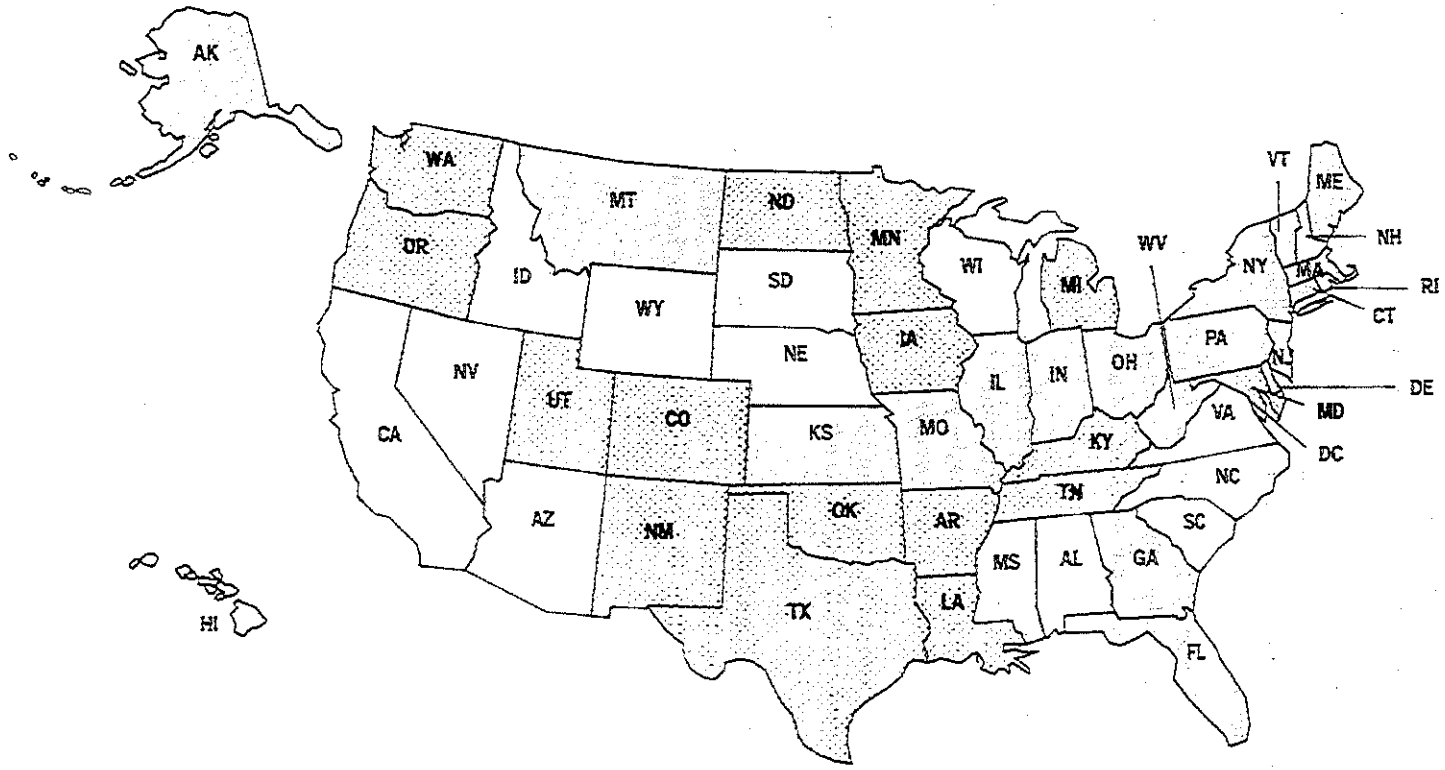

STATES WITH NO MAC TRANSPARENCY LEGISLATION ENACTED

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STATES WITH MAC TRANSPARENCY PENDING 2015